UnitedHealthcare®
A UnitedHealth Group Company

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Seena Perumal Carrington
Acting Commissioner
Massachusetts Division of Health Care Finance and Policy
Two Boyleston Street
Boston, MA 02116

Re: Testimony Regarding Health Care Provider and Insurer Costs and Cost Trends

Dear Acting Commissioner Carrington,

In response to your request for written testimony by letter dated May 27, 2011, I am hereby submitting responses on behalf of UnitedHealthcare of New England, Inc. We have set forth below the questions posed by the Division and the Attorney General's Office and our responses in the order set forth in your May 27, 2011 letter.

If you have any questions regarding this submission, please direct them to the undersigned.

Very truly yours,

Stephen J. Farrell
President and CEO

Division of Health Care Finance and Policy Questions – Exhibit B

1. After reviewing the preliminary reports located at *www.mass.gov/dhcfp/costtrends,* please provide commentary on any finding that differs from your organization's experience. Please explain the potential reasons for any differences.

   With regard to the Price Variation report, United agrees, in general, with the conclusions of the report – variation in prices is driven by factors other than simply quality measures.

   Regarding the Premium report, we agree that premium increases exceed inflation, small groups pay more than large groups and employers are "buying down" to reduce their premium costs.

   Finally, we also find that unit cost is a significant driver in health care cost trend. Unit cost trend as well as an increase in the intensity of services rendered are two of the biggest contributors to trend.

2. We found that – when adjusted for all factors (benefits, demographics, geography, etc.) – small businesses are paying more for premiums and have experienced sharper growth in rates than mid-size and large employers. Is this finding consistent with your organization's experience? Please comment on why you think this is happening and what can be done to assist small employers.

   The Division's finding is consistent with our experience. Consistently higher rate of growth of medical spending in small group market in comparison to large group is pushing premium rates in that population higher at a comparatively accelerated rate. Here we have outlined some of our efforts to slow growth in medical spending.

   United has implemented or is in the process of implementing a wide range of initiatives designed to promote the practice of evidence based medicine, efficient delivery of care and to provide consumers with the tools that they need to make informed health care decisions. These initiatives include, but are not limited to, programs that provide consumers with quality and cost information regarding healthcare providers, targeted efforts to inform consumers regarding the availability of network providers, and expanded availability of nurses and case managers, as well as recurrent efforts to negotiate lower reimbursement rates with providers.

   In sum, quality care leads to lower costs. We think consumers obtaining coverage either on an individual basis or through a small employer plan will in particular benefit from our initiatives focused on providing consumers with more information to make informed healthcare decisions about quality and cost. In general, large employer groups have traditionally had better resources available to their employees in this regard.

3. What are some of the non-medical drivers (not related to health care prices or utilization) that have led to premium growth in recent years? What is your organization doing to minimize their impact on premium costs?

In general our non-medical expenses, with the exception of premium tax, increase at a much lower rate than medical expenses. We strive to streamline internal and external processes to continuously drive efficiency which reduces our non–medical expenses.

4. What systemic actions do you think are necessary to mitigate health care cost growth and health insurance premium growth in Massachusetts?

As reported by the Massachusetts Attorney General, the market leverage of certain health care providers and the prices they charge is a major driver of health care costs in the Commonwealth. We believe that implementing parameters around rate increases for outlier providers should be considered as a policy response to achieve some re-balancing of the provider delivery system. Payment reform alone may not address the disparity in prices.

UnitedHealthcare is implementing Performance Based Contracting in Massachusetts with certain providers, which will tie future increases to improvement on quality and efficiency metrics. We believe that performance based contracts have the opportunity to achieve meaningful medical cost trend reduction while improving the quality of health care members receive.

In addition, we believe transparency of quality and cost information for both members and employer groups is important to assist in educated decision making regarding provider choice for particular services.

Another important area to address is administrative simplification between health plans and providers. Administrative simplification and streamlining of communication among providers should also be addressed. This should not be limited to providers who are members of the same system but across all providers in the state.

We also believe that addressing hospital readmissions is an important area of focus to both reduce the overall cost of care and improve the quality of care. United is focusing on this through our performance based contracts and generally through medical management. Readmissions to the hospital drive a significant amount of unnecessary health care costs. Improving the transition of care after hospital discharge will not only reduce health care costs but also improve the quality of care and quality of experience for our members.

5. What factors do you consider when negotiating payment rates for inpatient care, facility charges for outpatient care, and physicians, and other professionals? Please explain each factor and rank them in the order of impact on negotiated rates.

Factors and weight given to such factors will vary depending on individual circumstances but in general when negotiating rates we consider the following factors:

1) **what we are currently paying the provider compared to their costs to provide the service; 2) what we are currently paying the provider compared to similar providers of service in that geographic area; 3) what we are currently paying the provider compared to what they are receiving from the competition to the extent that information is known; 4) when the provider last received an increase from United; 5) whether the provider is essential to have in the network for access and reputation reasons from both an employer group sales and membership retention perspective; and 6) current Medical CPI.**

United's own analysis supports the findings outlined in the Health Care Finance and Policy Executive Summary on Health Care Cost Trends. Hospital and physician group prices vary significantly within the same geographic area and amongst providers offering similar levels of services. Price variations are not correlated to quality of care, sickness or complexity of the population being served, the extent to which a provider is responsible for caring for a large portion of Medicare or Medicaid patients or whether the provider is an academic teaching or research facility. Price variations are not adequately explained by differences in hospital costs of delivering similar services at similar facilities.

6. Is there a material difference in how you approach contracts when you are contracting with a health care system vs. contracting with organizations representing a single facility or provider group?

   Each scenario requires analysis of the particular circumstances.

7. We understand that certain systems demand higher rates because of geographic isolation, specialty practice and reputation. Please explain your understanding of this dynamic.

   The issues noted by the Division above are critical factors in contractual negotiations. We would note that, as reported last year, while these factors have always existed the pattern has intensified in recent years with increased consolidation within the provider community. This has continued to intensify at an even faster rate in the past year. Particularly on the physician side, the consolidation is resulting in demands for significant increases to reimbursement rates.

8. What quality measures does your organization use to assess quality outcomes by provider? What incentives or consequences are there for providers based upon their performance?

We have a Premium Specialty Centers Program for Cardiac, Joint Replacement and Spinal Surgery. Any facility offering these services can apply to participate, however nationally recognized quality indicators must be met to be designated. Quality and efficiency information is published and available for members to make treatment decisions. However members can go to any facility even those who are not designated. The potential provider consequence is lack of designation and possible loss of volume.

United has a Hospital Comparison program with comparative quality (outcomes data – inpatient mortality and complications compared to national norms) and cost data by inpatient condition/procedure. This information is available to our members on our website.

United also has a Physician Premium Designation program for primary care and specialist physicians. Quality and efficiency designations are published but again members can access any participating physician in the network. We do not currently have this program in Massachusetts due to small market share.

9. What role do you think quality should play in determining prices, and does the health care community currently collect the right types of quality measures?

We believe increases to provider rates should be tied to performance measures including quality and outcomes measures. United has recently developed a performance based contracting methodology for both hospitals and physicians. Key areas we are initially addressing through this methodology include all cause readmission rates, average length of stay, imaging services delivered in the ER, provider performance on National Patient Safety and National Quality Improvement Goals and Hospital Consumers Assessment of Healthcare Providers and Systems (HCAHPS). Additional metrics will be added over time.

United has specifically identified all cause readmissions as an area of focus. Although this is a national contracting program, we note the Division of Health Care Finance and Policy findings that generally, based on current publicly available information, readmission rates in Massachusetts are generally higher than the rest of the country.

10. We found that for many inpatient DRGs, a large portion of patient volume is clustered in the most expensive quartile(s) of providers. Please provide your organization's reaction to these findings.

Our data confirms this finding. The majority of our hospital spend is with the providers who have the highest inpatient rates.

11. What tools should be made available to consumers to make them more prudent purchasers of health care?

We believe consumers should have access to condition specific quality and cost data and we are continually developing and improving tools to provide this information accurately and in a helpful format.

As mentioned earlier, United has a Hospital Comparison program with comparative quality and cost data by inpatient condition/procedure.

We also are developing a Consumer Transparency Initiative Program which will include physician and facility specific costs for treatments at both the unit and episode level, as well as provider treatment outcome information, consumer ratings and information on treatment options.

The UnitedHealth Premium® designation program was developed to provide credible, understandable information on health care providers and facilities that empowers consumers to make more informed decisions and motivates health care professionals to deliver high quality care at the lowest price – ultimately creating a better health care system for all.

To make it easier for consumers to navigate the health care system, we provide tools to compare physician and facility quality and cost information. The program also supports physicians and facilities in their efforts to improve care delivery by providing them with actionable feedback through high-level performance and detailed patient reports. Unfortunately due to our not having a sufficient volume of claims data for Massachusetts providers, the Premium Designation program is not available in the Commonwealth.

Our NurseLineSM decision support service connects consumers with specially trained nurse "coaches" who use a proactive coaching model combined with our powerful eSync PlatformSM technology, to connect consumers with the:

- **Right treatment—guidance on when and where to seek care**
- **Right provider—scheduling appointments with high- quality network providers**
- **Right medication—coaching on lower cost options, drug interactions and appropriate use**
- **Right lifestyle—referring to wellness and behavioral health service**

Our Cancer Support Program works with cancer centers clinically proven to provide exceptional care for patients with complex cancers. Treatment at these Centers of Excellence can result in a more consistently accurate diagnosis; care that is planned, coordinated and provided by a multidisciplinary team of experts who specialize in the patient's specific kind of cancer; appropriate therapy; fewer complications and higher survival rates; and shorter hospitalizations and lower costs.

12. What are the advantages and disadvantages of complete price transparency (e.g., consumers being able to see what prices are paid by carriers to different providers for different services) from your organization's perspective? What about complete quality transparency?

UnitedHealthcare has been a proponent of consumer-based transparency for some time. We currently provide our members with a significant amount of quality and cost data so that they can make more informed health care decisions. We believe it is important that price transparency be included with quality so that our members get a full representation of the cost and quality of a particular provider they may visit.

However we have not seen sufficient evidence that hospital contract transparency across payers more broadly has had any impact in reducing health care spending. In fact, we believe that such transparency has the potential to be inflationary by placing pressure for hospitals to demand payments at the highest end of the reimbursement spectrum.

13. What methods, if any, does your organization use to encourage consumers to use high value (high-quality, low-cost) providers? What has been the effectiveness of these actions?

United has implemented or is in the process of implementing a wide range of initiatives designed to promote the practice of evidence based medicine, efficient delivery of care and to provide consumers with the tools that they need to make informed health care decisions. These initiatives include, but are not limited to, programs that provide consumers with quality and cost information regarding healthcare providers, targeted efforts to inform consumers regarding the availability of network providers, and expanded availability of nurses and case managers, as well as recurrent efforts to negotiate lower reimbursement rates with providers.

14. Does your organization currently offer limited or tiered network plans? If so, please describe the level of interest and/or participation from groups and individuals, as well as any feedback you are aware of from those participating.

    a. Please also provide premium differences between the limited/tiered plans and comparable plans that have more open networks.
    b. Please also provide information about how you market and explain these options to employers and consumers.

Our organization does not currently offer limited or tiered network plans in MA.

15. Please respond to the trends presented in Table 20 from the Premium Trends Report. The total medical spending portion of premiums appeared to slow for 2009-2010 as compared to previous years. If your organization also experienced slowed medical spending, please explain the underlying factors. If your organization did not experience the slow-down in trends, please explain why your organization differed from the average.

We did not experience the slow-down in trends as demonstrated in Table 20. Our trends were primarily driven by health care intensive individuals.

16. Does your organization have any direct experience with alternative payment methods (bundled payments, global payments, etc.)? What has been you experience and the results in terms of quality performance and cost mitigation?

We do not have any experience in Massachusetts with alternative payment methods. In certain markets we have both physician and hospital capitation contracts. We also have gain share and risk share arrangements for Medicare with small to medium size groups of primary care physicians. Whenever the group is relatively small and tightly managed we have seen an improvement in quality and a reduction in the overall cost of care.

United also has patient centered medical home pilots in certain markets. The payment model is fee for service plus an administrative payment plus shared savings.

We currently reimburse transplant providers based on an episode bundled payment methodology. Our Transplant Resource Services contracts apply to the entire transplant event, with pre-negotiated rates for transplant related services performed at the contracted medical center, including pre-transplant evaluation, hospital and physician fees, organ acquisition and procurement, blood/marrow acquisition and donor search charges, transplant procedure and up to 12 months of follow-up care for transplant related services.

We are piloting with leading oncology groups a new reimbursement approach that reimburses oncologists up front for an entire cancer treatment program instead of the current fee for service model. The new program separates the oncologist's income from drug sales while preserving his or her ability to maintain a regular visit schedule with the patient.

17. Please identify any additional cost drivers that you believe should be examined in subsequent years and explain your reasoning.

One area responsive to this inquiry concerns excessive costs associated with non-contracted providers. Certain specialty areas and service locations are not incented to contract with any health plan because utilization of their services cannot be influenced by the health plan. This is particularly problematic in regions with a high preponderance of Managed Care Plans where such providers can obtain billed charges (including balancing billing plan members in large amounts), which in some instances are not reasonably

related to costs of services provided. The best example of this concern arises with facility-based providers.

18. Please provide any additional comments or observations you believe will help to inform our hearing and our final recommendations.

Cost shifting to commercial plans becomes more pronounced over time as reduced Medicare and Medicaid payments do not cover the cost of care for many providers.

Attorney General Office Questions – Exhibit C

1) Please explain and submit a summary table showing the range of your aggregate health status adjusted relative commercial prices or payments from 2009-2010 for each acute care hospital and large physician group in Massachusetts (i.e., physicians who contract through a PHO, IPA, multi-specialty group, or other group arrangement). If the aggregate health status adjusted relative commercial prices or payments from 2009-2010 that you submitted to the Office of the Attorney General differ from the information provided to the Division of Health Care Finance and Policy, please explain the differences and why such differences exist.

   See the attached Appendix 1 and Appendix 2 for the summary tables. These tables were produced based on information provided to the Division of Health Care Finance and Policy.

2) Please explain and submit documents to support how you quantify the amount of, and adjust the amount of, risk being shifted to providers in your network, including risk on self insured as well as fully insured plans. Include in your response any distinction you make between performance and insurance risk.

   At this time we do not participate in provider risk contracts.

3) Please explain and submit documents to support how you quantify the total amount that you negotiate to pay at-risk providers on their total commercial business including HMO and PPO, risk and fee-for-service payments. Include in your response how you value any various aspects of provider risk contracts (e.g., carve-outs for certain services such as behavioral health or high cost pharmaceuticals; attachment points beyond which services are not chargeable against the risk budget; quality payments; fees; and other similar negotiated aspects of the contract).

   At this time we do not participate in provider risk contracts.

4) Please explain and submit a summary table showing the range of health status-adjusted fully-loaded total medical expenses you paid on a per member per month basis from 2009-2010 for each Massachusetts provider in your network who contracts through a PHO, IPA, multi-specialty group, or other group arrangement, with each provider identified by whether it was paid based on a negotiated per member per month amount against which all allowed claims costs are settled for the purposes of determining the amount of withhold returned, surplus paid, and/or deficit charged to a provider. "Fully-loaded" means inclusive of all administrative, medical management, and other supplemental payments, including but not limited to bonuses, grants, infrastructure funding, and reinsurance recoveries. If the health status-adjusted fully-loaded total medical expenses you paid on a per member per month basis from 2009-2010 that you submitted to the Office of the Attorney General differ from the information provided to

the Division of Health Care Finance and Policy, please explain the differences and why such differences exist.

Please see the attached Appendix 3 and Appendix 4 for the summary tables. These tables were produced based on information provided to the Division of Health Care Finance and Policy.

5) Please explain and submit a summary table showing your premium trends from 2005 to 2010 with details on how much of your premium trend resulted from increases in administrative costs, reserve practices, and medical trend, including the proportion of medical trend that resulted from (1) health care provider unit price increases, (2) changes in utilization, and (3) all other factors, such as changes in mix of services, mix of location of services, member demographics, and plan design. Please explain how you track each of these components with respect to providers in your network who are paid on a per member per month budget arrangement (whether at-risk or "upside only").

Response (1) – (3): Table below summarizes available data at the time of this request related to pricing trends.

Category	2008	2009	2010
Core Trend [1]	-4.0%	11.2%	14.7%
Demographics	1.4%	2.0%	1.7%
Business / Product Mix [2]	-5.0%	-2.5%	-3.6%
Total	**-7.5%**	**10.6%**	**12.4%**

[1] Core Trend includes: Unit Cost, Utilization, Mix of Services, Leveraging, Work / Calendar Days
[2] Business / Product Mix includes: Customer Mix, Benefit Plan Changes, Business Mix

Our organization does not currently contract on a per member per month budget arrangement in MA.

6) Please explain and submit supporting documents that show what affect, if any, limited network or tiered products have had on premium trend.

Our organization does not currently offer limited or tiered network plans in MA.

7) Please provide a summary table showing your membership by year from 2005-2010, including: (1) what percent of your members are enrolled in HMO/POS PPO, and indemnity, (2) within each product category (HMO/POS, PPO and indemnity), what percent of your members are fully-insured, self-insured, or other, and (3) within each product category (HMO/POS, PPO and indemnity), what percent of your members are enrolled in tiered or limited network products.

	2006	2007	2008	2009	2010
Fully Insured Member Months	338,563	391,525	394,708	358,577	304,400
Self Funded Member Months	2,440,212	2,485,105	2,111,853	2,452,234	NA
Total Member Months	2,778,775	2,876,630	2,506,561	2,810,811	NA

Note: We are unable to report on archived 2005 data or calculate percentage of membership by product at this time. We were not able to produce the 2010 self-funded data at the time of this submission. We do not have any membership enrolled in tiered or limited network products at the present time.

8) Please explain and submit supporting documents that show how you evaluate the capacity of a provider to participate in a risk contract, including factors such as the provider's solvency, historical experience with risk payments, size, organizational structure, ways in which you adjust the provider risk budgets, and any other factor.

At this time we do not participate in provider risk contracts in MA.

9) Please explain and submit supporting documents that show whether and how you inform your members, or require providers to inform your members, when you reimburse providers for the services that they render to your members through a negotiated per member per month amount against which all allowed claims costs are settled for the purposes of determining the amount of withhold returned, surplus paid, and/or deficit charged to a provider (regardless of whether those providers are "at risk" or are "upside only").

At this time we do not participate in provider risk contracts in MA.

10) Please explain and submit supporting documents that show how you identify, audit, and/or prevent provider underutilization of needed services or avoidance of sicker patients where you reimburse those providers through a negotiated per member per month amount against which all allowed claims costs are settled for the purposes of determining the amount of withhold returned, surplus paid, and/or deficit charged to a provider (regardless of whether those providers are "at risk" or are "upside only").

At this time we do not participate in provider risk contracts in MA.

The foregoing statement, opinions and data were compiled from responses provided to me by employees of United and are true and correct to the best of my knowledge and belief.

I affirm that I am legally authorized an empowered to represent UnitedHealthcare of New England, Inc. for the purposed of this testimony, and that the testimony is signed under the pains and penalties of perjury.

Dated this 17th day of June, 2011

UNITEDHEALTHCARE OF NEW ENGLAND, INC.

Signed:

Stephen J. Farrell
President and CEO